APRIL 2009

Policy Brief

Commonwealth Medicine
UMASS MEDICAL SCHOOL
Applied Knowledge in Public Service

Vermont Choices for Care
Policy Brief: Quality Oversight

Summary of Policy Brief

The Department of Disabilities, Aging, and Independent Living (DAIL) oversees quality of Choices for Care (CFC) services, mainly through two divisions. Specifically, the Division of Disability and Aging Services (DDAS) conducts on-site reviews of all CFC home- and community-based services (HCBS) agency providers, using standards that emphasize consumer outcomes. The Division of Licensing and Protection conducts licensing/certification of nursing facilities, enhanced residential care facilities, and home health agencies based on federal and state standards that emphasize process outcomes. This organizational structure, however, has created overlapping procedures, gaps in the quality oversight of CFC independent providers, and review standards that do not fully reflect the goals of CFC.

In light of these challenges, we propose that DAIL take the following actions to enhance its quality oversight of CFC services:

- Create a standing quality committee within DAIL to coordinate quality activities and exchange information
- Modify licensing standards that encompass consumer-directed principles
- Maximize the use of desk reviews of quality assurance data, when appropriate, e.g., licensing data
- Conduct comprehensive reviews of case management agencies based on CFC desired outcomes
- Use the DDAS annual large-scale surveys as the primary vehicle for monitoring CFC consumer outcomes, and follow-up with in-depth interviews to study specific issues and to identify mechanisms to address these issues

Commonwealth Medicine 333 South Street, Shrewsbury, MA 01545 tel. (508) 856-8148
www.umassmed.edu/commed

Purpose of Policy Brief

This policy brief is the third in a series of reviews of policies and procedures related to the implementation of the Vermont Choices for Care (CFC) Initiative. The purpose of these policy briefs is to examine key policy questions and provide an external perspective to help the Vermont Department of Disabilities, Aging, and Independent Living (DAIL) to ensure that policies and procedures are as effective as they can be in supporting CFC goals. More specifically, this policy brief discusses the division of responsibilities for quality assurance oversight of CFC services and the standards and procedures for directly monitoring these providers.

Key Questions for this Review:

A. What entities have responsibilities for direct oversight of CFC providers?

B. What standards and procedures do DAIL divisions use to monitor their CFC providers?

C. To what extent is the distribution of quality assurance responsibilities efficient?

D. To what extent are the standards and procedures for provider reviews consistent with CFC goals?

E. How should the state modify its procedures for the oversight of CFC in order to maximize their effectiveness?

In the discussion section, we first describe the state entities with direct oversight of CFC providers and the standards and procedures these entities use to conduct their provider reviews. We then discuss the strengths and challenges inherent in the allocation of responsibilities for these reviews. More specifically, we review the extent to which the current allocation contains overlapping responsibilities, and we assess the extent to which the standards and procedures are consistent with CFC goals. In the recommendations section, we describe options for modifying the provider review standards and procedures to increase their efficiency and strengthen their relationship to CFC goals.

Policy Overview/Background

The overarching goal of CFC is to support adults with physical disabilities and older Vermonters with long-term care needs in a setting of their choice. For instance, CFC covers long-term supports in a multitude of settings — individual homes and apartments, adult day centers, enhanced residential care facilities (ERCs), and nursing facilities. Under the umbrella of the HCBS setting, two additional settings are available: 24-hour individualized residential care and the Program for All-Inclusive Care for the Elderly (PACE). The types of services in HCBS settings include adult day services, case management, homemaker, personal care, companion, respite, and assistive devices or home modifications. As a consequence of funding this broad range of services across settings, DAIL is responsible for overseeing a diversity of providers. Such providers include nursing facilities, ERC operators, adult day providers, home health agencies, area agencies on aging, 24-hour individualized residential care contractors, a fiscal intermediary, and independent workers (such as family members) hired by consumers.

DAIL is responsible for assuring the quality of these services. While "quality" can be conceptualized in many ways,[1] the conceptual basis that guides this policy brief is the "discovery, remediation, and improvement" cycle for HCBS quality put forth by the Centers for Medicare & Medicaid Services (CMS), the federal oversight entity of CFC. Under a single program or funding source, such as CFC, different entities can engage in any one or all of the discovery, remediation, and improvement functions to help assure service quality. Entities such as DAIL or direct care providers can engage in one or more of these functions with respect to some aspect of program implementation. For example, a DAIL unit may engage in discovery by generating information to be used for remediation by another unit, or the same unit. Direct care providers could apply this framework, through consumer experience feedback (e.g., complaints), to identify and remediate issues on a case-by-case basis.

In addition to consumer feedback, other quality assurance mechanisms exist, such as provider contracting standards and related reviews (Booth, Fralich, and Bowe, 2005; Fralich, Booth, Gray, Bowe, and Bratesman, 2005). In this quality oversight policy brief, at the request of the Vermont DAIL, we focus on two types of provider reviews conducted by two constituent divisions within DAIL: on-site reviews/certification conducted by the Division of Disability and Aging Services (DDAS) and licensing/certification by the Division of Licensing and Protection (DLP).

Findings and Discussion

A What entities have responsibilities for direct oversight of CFC providers?

DAIL is responsible for assuring quality of CFC long-term care services. To help meet this responsibility, DAIL conducts provider monitoring or licensing through the DDAS and the Division of Licensing and Protection (DLP). Until fall 2008, DDAS provider reviews were conducted by its Quality Management Unit.[2] (CMS is also responsible for oversight of the many CFC providers who deliver Medicare-reimbursed services. CMS contracts with DLP to certify these providers.)

The provider review responsibilities are divided along the lines of whether or not a provider is subject to licensing or certification regulations, although there are overlaps, as discussed below. Specifically, DLP conducts licensing of nursing facilities, enhanced residential care facilities, and home health agencies. (All these entities are CFC providers and also need certification in order to receive reimbursement from Medicare, Medicaid, or state-funded sources, as appropriate.) Until fall 2008, the Quality Management Unit (QMU) within DDAS conducted provider reviews of CFC HCBS providers, including adult day providers, home health agencies, case management entities, and others. (The Quality Management Unit had also been reviewing HCBS providers of traumatic brain injury and developmental disability services.) In addition, DDAS and the Business Office (both constituent entities of DAIL) jointly oversee the operations of the CFC fiscal intermediary, which processes payroll for CFC participants who hire their own workers (participants in consumer-directed care, surrogate-directed care, or Flexible Choices).

[1] Dimensions of quality, according to the Institute of Medicine, are safe, effective, timely, person-centered, equitable, and efficient. In addition, a conceptual framework for quality endorsed by many is the structural, process, outcome framework.

[2] In 2008, DDAS, the umbrella division of which the Quality Management Unit is part, was reorganized. The reorganization led to the decentralization of the Quality Management Unit's functions, which were subsequently placed in various units in DDAS.

Although agency providers are subject to DAIL oversight, CFC independent providers (providers in consumer-directed, surrogate-directed, or Flexible Options) have not been subject to any formal review mechanism beyond the expectations of the person who hires them. Instead, there are some safeguards in place to help ensure quality of services rendered by these independent providers. For example, the fiscal intermediary must conduct background checks on independently hired providers to help ensure participant safety. Another safeguard is the case managers' support to CFC participants or surrogates as they execute their employer responsibilities, such as hiring and managing workers. (Participant "safeguards" represent a domain of the CMS HCBS Quality Framework.) See Table 1 for the type(s) of direct provider review for each type of CFC provider.

B What standards and procedures do DAIL divisions use in their provider reviews?

The DDAS/Quality Management Unit and the Division of Licensing and Protection have used different standards and procedures in their provider reviews. The DDAS/QMU used several sets of standards to guide their provider reviews. Overall, providers were reviewed against desired outcomes from the CMS Quality Framework for HCBS and the DDAS Quality Management Plan's service values (Quality Management Plan, 2007). The desired outcomes of the CMS Quality Framework and the Quality Management Plan are depicted in Table 2.

Table 1: Review Type by CFC Agency Provider Type

Provider Types (CFC services they provide)	Division of Disability and Aging Services Review/ Certification[a]	Division of Licensing and Protection Licensing/ Certification	Federal oversight
Adult day providers	X		X[c]
Case managers (affiliated with home health agencies)	X		
Case managers (affiliated with area agencies on aging)	X[b]		
Home health agencies (nursing, home health aides, and physical, occupational, and speech therapy)	X[f]	X	X
ERCs		X	
Nursing Facilities		X	X
24-hour individualized residential care providers[d]	X	Licensed by Department of Mental Health	
ARIS (fiscal intermediary service)	X		
Transitions II (support brokerage)	X		
Unlicensed providers of HCBS (personal emergency response, assistive devices, home modifications)[e]			
Independent providers (homemaker, personal care, companion, respite)			

[a] This review was conducted by the former Quality Management Unit.
[b] DAIL has developed case manager standards and certification procedures.
[c] In addition to Vermont certification, adult day centers that are PACE providers (there were two at the time of this writing) are also subject to a federal/PACE review during the first three years of operation. Adult day providers that receive other funding sources (e.g., Veteran Affairs) may have additional certification requirements.
[d] Because the contractors for this service are mental health services organization, they are concurrently licensed by the Department of Mental Health.
[e] Such providers to CFC participants may be licensed by other state entities for compliance with building codes or other requirements.

Table 2: Desired Outcomes of Quality Management Plan and CMS Quality Framework

Quality Management Plan	CMS Quality Framework
1. Self-Determination [a]	A. Participant Rights and Responsibilities
2. Respect	B. Participant Outcomes and Satisfaction
3. Independent Living	"
4. Relationships	"
5. Participation	"
6. Person-Centered Practices	C. Person-Centered Planning and Delivery
7. Well-Being	D. Participant Safeguards
8. Communication	
9. Collaboration	E. Provider Capacity and Capabilities
10. Trained and Competent Support Systems	"
"	F. Access
"	G. System Performance

[a] Desired outcomes 1-8 are identical to Division of Disability and Aging Services consumer values.

These desired outcomes, in turn, form the foundation for the data collection instruments and procedures DDAS/QMU used during their on-site provider reviews. The data collection procedures and instruments were as follows:

- Consumer interviews with a 10 percent sample of CFC consumers at each provider agency. The interviews had been conducted by the QMU staff using the Personal Experience Survey.[3]
- Family and guardian interviews, if possible
- Consumer record reviews using a checklist developed by the QMU based on the Quality Management Plan standards.
- Provider record reviews using a checklist developed by the QMU based on the Quality Management Plan standards.
- Provider staff and provider management interviews by QMU staff.

A written report was then drafted for each provider, based on the data gathered from the QMU's on-site reviews. Each report documented findings and recommended actions to be taken by the provider by level of importance: critical (most important), significant, and moderate (least important).

While standards for CFC HCBS providers are based on a combination of consumer outcomes and system outcomes from the CMS Quality Framework, the licensing/certification standards for other CFC providers — nursing homes, ERCs, home health agencies — are more prescriptive, focusing on the provider processes. For example, licensing/certification regulations cover how services are provided (such as requirements for nutrition in an ERC or licensed nurse aides in home health agencies) and how records are kept. See Table 3 for licensing and certification standards of various CFC agency providers and how these standards cross-walk with the CMS Quality Framework (Vermont Agency of Human Services, 2001; DAIL, 2007; DAIL, 2004).

[3] Under the sponsorship of the U.S. Department of Health and Human Services, the Personal Experience Survey, a survey instrument, was developed as a technical assistance tool for states to use to elicit feedback from HCBS waiver recipients about their services. Originally developed in 2003, the Personal Experience Survey underwent testing prior to its release (e.g. cognitive interviews and field testing). There are currently several versions of the Personal Experience Survey for different populations, including older persons and adults with physical disabilities.

Table 3: Crosswalk between domains of CMS Quality Framework and major licensing/certification areas of NFs, ERCs, Home Health Agencies, Adult Day Providers, and Case Managers

Licensing/Certification Domains by CFC Provider Type					
CMS Quality Domains	**Nursing Facilities' Licensing Domains**	**ERC's Licensing Domains**	**Home Health Agencies' Licensing Regulations**	**Adult Day Providers' Certification Standards**	**Case Management Certification Standards**
Access					Information and referrals
Person-Centered Planning/Delivery	Resident assessment, comprehensive care plans, transfer agreements		Patient assessment, plan of care	Patient records (including assessment, service planning)	Assessment and re-assessment, service plan and monitoring
Participant Rights and Responsibilities	Residents' rights	Residents' rights, resident funds and property	Discontinuation of services, patient rights	Participant policies, including grievance policy, rights policy	
Satisfaction and Outcomes	Quality of life, quality of care				Consumer satisfaction with case management
Safeguards	Disaster and emergency preparedness			Program administration, including criminal background checks, training, abuse registry checks	Participant's informed choice regarding acceptable risk
Provider Capacity and Capability	Nurse aide training; Professional staff; Laboratory, radiology, and other diagnostic services; physical environment	Resident care and home services, laundry services nutrition and food services, pets, physical plant	Skilled nursing services, licensed practical nurse services, licensed nursing assistant services, therapy services, medical social services, unlicensed caregiver services	Adult day services, nutrition and food services, staff, paid program consultants or contractors, facility	Case management exam
System Performance	Administration, clinical records, quality assessment and assurance, enforcement, administrative review and appeals		Organization, services, and administration, clinical records, survey and review, quality assurance and improvement, enforcement, appeals	Governing body, agency contracts, quality assurance process, program policies	Efficient and effective service plan

Note: Licensing/certification requirements for each type of provider were mapped against the CMS Quality Framework domains that were considered by the authors to be the best fit. It is possible that any given licensing/certification requirement could be classified into another domain of the CMS Quality Framework.

To gather information relevant to these licensing standards, the Division of Licensing and Protection uses the following procedures:

- Observation of resident care processes and environment
- Interviews with a sample of residents and family members
- Interviews with the provider's staff, e.g., nursing home's caregiver and administrative staff
- Review of clinical records
- Fire safety inspection and other physical regulations, such as safe storage of food, and protection from physical or mental abuse

Recent discussions at DAIL have led to an examination of the relative merits of the provider review arrangement as described above. Under particular scrutiny is the allocation of responsibilities for provider reviews and the standards and procedures used in the reviews of HCBS providers. We now discuss the relative strengths and challenges posed by the arrangement described above.

C To what extent is the distribution of quality assurance responsibilities efficient?[4]

As discussed, between DLP and DDAS, all agency providers of CFC services have been subject to some form of regular state reviews, either licensing/certification through the Division of Licensing and Protection, or DDAS (most of DDAS oversight took the form of on-site monitoring through DDAS' former Quality Management Unit). Some agency providers — such as nursing facilities, ERCs, and some case managers (area agency on aging case managers) — are reviewed by one of the two agencies. However, home health agencies are reviewed through both the DLP licensing/certification process and the DDAS provider review. Such overlap places unnecessary resource burdens on DAIL and providers alike. For instance, DDAS/QMU's comprehensive data collection on a few participants at each agency expends substantial state resources, e.g., on logistics. Furthermore, separate reviews by DAIL entities create separate repositories of data. Lastly, it is unclear whether DDAS should continue to be responsible for certifying adult day providers, whose provision of nursing and therapies may more appropriately require oversight from DLP.

While there are areas of overlap in oversight for agency providers, the procedures for directly assessing independent workers are more limited and more decentralized. This is partly due to the geographic dispersion of independent workers; the dilemma of how to oversee independent workers without undermining consumer direction; and the difficulty of overseeing workers who are also family or friends of the consumer. Nevertheless, QMU had gathered very limited information directly from some participants in consumer-directed or surrogate-directed care through its on-site provider reviews. In addition, some outcomes related to self-directing participants and their hired workers are monitored through the combined efforts of DDAS, the DAIL Business Office, and the fiscal intermediary. For instance, these entities oversee billing/cash flow, complaints regarding fiscal intermediary services, and background checks on potential employees. However, given the fact that a substantial proportion of CFC participants receive services from independent providers, quality assurance related to independent providers and the participants whom they serve should receive attention commensurate to their role as a major service delivery type.

D To what extent are the standards and procedures for provider reviews consistent with CFC goals?[5]

Not surprisingly, the standards against which providers are assessed differ by provider type and by the organization conducting the reviews. The Quality Management Plan focuses on participant outcomes such as quality of life (respect and

[4] For this section, efficiency denotes the degree to which quality management resources are allocated in a way that produces adequate oversight without duplication of efforts.

[5] For the purpose of this section, consistency with CFC goals is defined as the extent to which procedures meet desired outcomes as defined in the CFC evaluation logic model.

participation) and person-centeredness (self-determination and person-centered practices), which were intended to cover multiple populations/programs, e.g., persons with intellectual disability and older Vermonters with physical impairments.

The focus on consumer outcomes indicates DAIL's commitment (and that of its constituent divisions) to the well-being of the individual Vermonters receiving their services. These outcomes drove the consumer interviews conducted by the Quality Management Unit and other consumer surveys.[6] However, structuring HCBS provider reviews based on the Quality Management Plan and CMS Framework has created several challenges for DAIL, particularly when applied uniformly to all providers.

- First, it is unclear whether the same consumer outcomes should apply to very different providers. For example, should a home health aide be assessed on the criterion of "independent living"?
- If these consumer outcomes should apply uniformly to all types of HCBS agencies equally, then criteria for meeting such an outcome needs to be further clarified. For instance, what documentation is necessary to demonstrate that a case manager or an adult day provider has supported "relationships"? The lack of precision with which desired outcomes are operationalized makes the evaluation of these outcomes based on the rater's or reviewer's subjective assessment (rather than objective) and hence less reliable.
- Most importantly, because many of the desired outcomes are more meaningful across CFC, rather than specific to each CFC provider, assessing the degree to which each provider meets these outcomes for their CFC enrollees is not necessarily informative. This is exacerbated by the fact that some agency providers served few CFC participants and the sample drawn by QMU was even smaller.

In contrast, the DLP's licensing and certification standards have been defined in regulations and are more provider-specific in nature. On the one hand, licensing/certification standards help ensure that CFC desired outcomes are met, e.g., that care planning occurs, and that effective care is provided. On the other hand, these standards do not necessarily reflect the consumer outcomes of most interest to CFC. For example, standards do not address whether the provider has processes in place to support participant decision-making.

Likewise, the standards for independent providers are substantially different from those applied to agency providers. Independent providers are subject to individual standards set by participants/surrogates who hired them. While allowing these individual-based standards to drive quality assessment of independent providers is consistent with the principle of consumer direction, it challenges DAIL's ability to detect and understand systemic issues that may arise.

Recommendations

How should the state modify its procedures for oversight of CFC in order to maximize its effectiveness?

Taken together, the gap in quality assurance, areas of overlap, and the use of multiple sets of standards provide an opportunity for DAIL to find more effective quality oversight procedures, that also make the best use of scarce resources.

Agency-specific licensing and certification of many CFC provider agencies will continue to be conducted by the Division of Licensing and Protection and the Division of Disability and Aging Services.

Of present interest is how DAIL should allocate its scarce resources to provide the most effective complement to this existing provider-specific mechanism while reducing unnecessary duplication of effort and remaining consistent to CFC desired outcomes.

DAIL should consider adopting the following proposals:

A. **Create a standing quality committee within DAIL:** DAIL may want to set up a quality "workgroup" that coordinates quality improvement activities across programs. This would allow the separate entities to share best practices as well as quality assurance data generated.

[6] DAIL also conducts an annual consumer survey in which quality of life is assessed for both DAIL service recipients and general Vermonters.

Coordination is still crucial because DAIL oversees quality of non-CFC agency services, which may nevertheless be delivered by providers with CFC clients, e.g., providers of traumatic brain injury services, area agencies on aging. In other words, this could create a forum for DAIL to better identify quality-related issues, prioritize quality improvement projects, and identify ways quality assurance procedures may be improved. For example, quality improvement projects could include the state working with a provider type to improve internal quality assurance procedures, such as implementing peer reviews of client records. Lastly, the workgroup would be well-positioned to identify future improvements to DAIL's quality improvement processes, including exploring the feasibility and pros and cons of designating DLP as the certification entity for adult day providers.

To meet these purposes, such a workgroup could include major program managers (e.g., CFC waiver manager, Division of Licensing and Protection, DAIL divisions involved with quality management), as well as some providers and consumer stakeholders. Most importantly, this forum could ensure that quality data gathered by various DAIL divisions are used for continuous quality improvement.

B. **Modify licensing standards that encompass consumer-centered principles:**
DAIL leadership could initiate discussions with DLP and DDAS to explore the possibility of enhancing licensing reviews by introducing more consumer-centered principles into the review criteria. For instance, DLP could seek documentation from licensed providers to demonstrate that their service plans are person-centered and designed to maximize the individual's potential for self-determination. Alternatively, the reviews might seek documentation of collaboration between the licensed providers and other providers working with the individual. Such criteria, once they are clearly defined, could be incorporated into the licensing review as part of a new definition of "good care."

C. **Analyze licensing data of CFC providers against CFC desired outcomes:**
To make the most use of currently collected data, the information from licensing/certification reviews of CFC providers (e.g. nursing facilities, ERCs, home health agencies) should be shared with DDAS as much as possible. Presently, data on licensing deficiencies and bed capacity changes by provider type are shared. Licensing findings related to providers' service capacity or ability to coordinate with other providers will also be relevant to DDAS' ability to make improvements to CFC as a whole. For example, ERC facilities' ability to meet CFC participants' needs could affect hospitalization or emergency visits. Furthermore, reductions in ERC or nursing facility beds in a specific locale may have an unintended effect of keeping Medicaid beneficiaries in hospitals longer than necessary. Since both scenarios could drive up Medicaid spending, DDAS would benefit from knowing how individual providers meet CFC participants' needs and how their capacity can affect whether CFC participants have access to the appropriate and least expensive setting of care. (Quality improvement projects could also be developed with licensed/certified agency providers, such as ERCs, based upon the findings of the licensure data analysis.)

D. **Maximize desk reviews of providers' quality assurance data/reports:**
Desk reviews of quality-related data have several advantages. They offer an efficient way to analyze provider data prior to an on-site review. While not obviating the need for on-site document reviews, desk reviews can help reviewers better plan for on-site reviews. Furthermore, in times of particularly scarce resources, desk reviews can maximize the value of existing data and help prioritize which providers or issues require greater scrutiny. Lastly, when multiple types of data exist on a specific population (e.g., data related to independent workers and their employers) desk reviews are an efficient use of resources.

E. **Conduct comprehensive reviews of case management agencies:**
To the extent that DAIL has resources to devote to more comprehensive agency-based reviews, these resources could be allocated to oversee the case management agencies. These agencies are responsible for the overall coordination of all long-term supports received by CFC participants residing in the community. Therefore, their records are likely to have the most comprehensive and integrated information on how an individual's needs are being met. Furthermore, because a case manager's service planning and supportive role transcends settings and individual services, the case manager is critical to meeting CFC desired outcomes, including "information dissemination," "access," "participant self-reported quality of life," "care coordination," and "effectiveness."

Also, given the much smaller number of these agencies, DAIL could select a representative sample of clients from each case management agency and conduct more comprehensive reviews that include interviews with the case managers, clients, and providers along with the record reviews. In order to make the most efficient use of resources, DAIL might schedule reviews with specific case management agencies every two years unless problems are identified.

F. **Collect CFC community residents' feedback using large-scale survey:**
It seems most useful to concentrate the DDAS resources on a single CFC consumer feedback mechanism, as opposed to conducting provider-specific consumer surveys. Currently, the Data and Planning Unit within DDAS conducts an annual Vermont consumer survey through an independent survey contractor. Since this consumer survey is large in scale, it offers comparisons across CFC sub-populations as well as CFC and non-CFC populations. As this survey also includes questions on consumer outcomes of interest to CFC and other DAIL services, this could serve as the primary mechanism for understanding CFC consumer outcomes, such as participation, independent living, and other consumer outcomes.

This survey mechanism also offers a crucial opportunity to assess outcomes related to CFC independent providers hired by consumers, e.g., whether participants hiring independent providers have back-up help available or whether CFC participants have enough help to manage their independent workers. Therefore, enhancing this survey to better understand key outcomes of independent providers would fill in the gap in the assessment of independent providers.

The value of the survey lies not only in its ability to assess outcomes for the entire CFC community population but also in its capacity to be merged with other CFC-wide databases. For instance, survey data can be linked with service plan data and assessment data to yield in-depth analysis on how specific CFC services' and participants' functioning levels may be related to individual outcomes or satisfaction with CFC services. Such analysis makes maximum use of existing data collection efforts for quality improvement.

G. **Use consumer, provider, and stakeholder interviews to help identify solutions to systemic issues:**
The DDAS annual consumer survey could be supplemented with more focused interviews or focus groups with CFC client subgroups, depending on the issue at hand. For example, if the surveys found that a higher percentage of CFC consumers using a particular type of service were less likely to report that they were treated with respect, DAIL could select a group of CFC individuals using that service to conduct in-depth interviews to better understand their experience of care. Simultaneously, interviews with providers and other stakeholders could be used to identify which policies and procedures might be contributing to the issues identified and how these policies and procedures might be improved. Thus, a CFC-wide survey coupled with in-depth interviews could help DAIL to identify and understand the nature of systemic issues as well as to devise the solutions to resolve these issues.

Conclusions

DAIL has built a solid foundation for quality improvement for CFC by articulating its desired outcomes for consumers and incorporating these outcomes into its agency provider monitoring and consumer survey. Yet, DAIL has opportunities to strengthen this foundation. If implemented, the mechanisms recommended above can make better use of state resources for data collection, enhance data collection and analysis, and improve coordination within DAIL. Taken together, such mechanisms will allow DAIL to identify reliably any systemic challenges facing CFC (as well as best practices) and make appropriate improvements.

Appendix

The development of this policy brief was based on a review of the following written materials:

- Quality Management Plan (2007). Department of Disabilities, Aging, and Independent Living (2007).
- Quality Services Reports of selected HCBS providers (developed between 2006 and 2007). Quality Management Unit/Division of Disability and Aging Services.
- Standards for Adult Day Services in Vermont (2004). Vermont Department of Disabilities, Aging, and Independent Living.
- Licensing and Operating Rules for Nursing Homes (2001). Vermont Agency of Human Services.
- Regulations for the Designation and Operation of Home Health Agencies (2007). Vermont Department of Disabilities, Aging, and Independent Living.
- Residential Care Home Licensing Regulations (10/3/2000). Vermont Agency of Human Services.
- Individual Case Management Standards, Division of Disability and Aging Services.

In addition, input and feedback from the following individuals in DAIL were particularly informative for the policy review:

- Joe Carlomagno, Operations Director, DDAS
- Adele Edelman, Director, Adult Services Unit, DDAS
- Merle Edwards-Orr, Consumer Direction Manager, Adult Services Unit, DDAS
- Camille George, Director, State Unit on Aging, DDAS
- Bard Hill, Director, Data and Planning Unit, DDAS
- Frances Keeler, Director, Division of Licensing and Protection, DAIL

References

Booth, M., Fralich, J., Bowe, T. (2005). Home and Community-Based Services: Quality Management Roles and Responsibilities.

Fralich, J., Booth, M., Gray, C., Bowe, T., Bratesman, S. (2005). Discovery Methods for Remediation and Quality Improvement in Home and Community Based Services.

Galantowicz, S. (2006). Using Consumer Surveys for Quality Management: A Modified PES as One Option. Presentation to Cash and Counseling on July 11, 2006. Downloaded on March 30, 2009 www.cashandcounseling.org/resources/20060901-150844/PESConsumerSurveyDesign.ppt

Kilpatrick, A. O., & Johnson, J. A. (Eds.) (1999). Handbook of health administration and policy. New York : Marcel Dekker.

Institute of Medicine, Wunderlich, G.S., & Kohler, P.O (Eds.) (2001). Improving the quality of long-term care. Washington, D.C. National Academy Press.

U.S. Department of Health and Human Services Assistant Secretary of Planning and Evaluation. Vermont Adult Day. http://aspe.hhs.gov/daltcp/reports/adultdayVT.pdf

Contact Information

Darlene O'Connor
Commonwealth Medicine
University of Massachusetts Medical School
3 Centennial Drive
North Grafton, MA 01536

(508) 856-8148
darlene.oconnor@umassmed.edu

UMASS MEDICAL SCHOOL
Commonwealth Medicine
Applied Knowledge in Public Service